STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE REHABILITATION & HEALTH CARE CENTER	281 S CR 200 E CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	**INITIAL COMMENTS** Paper compliance t the Recertification and State Licensure Survey completed on December 18, 2013. Review date: January 21, 2104 Facility number: 000225 Provider number: 155332 AIM number: 100267670 Surveyor: Janelyn Kulik, RN Heritage House Rehabilitation and Healthcare Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 162, in regard to the paper compliance review to the Recertification and State Licensure Survey.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE